

FIG. 1

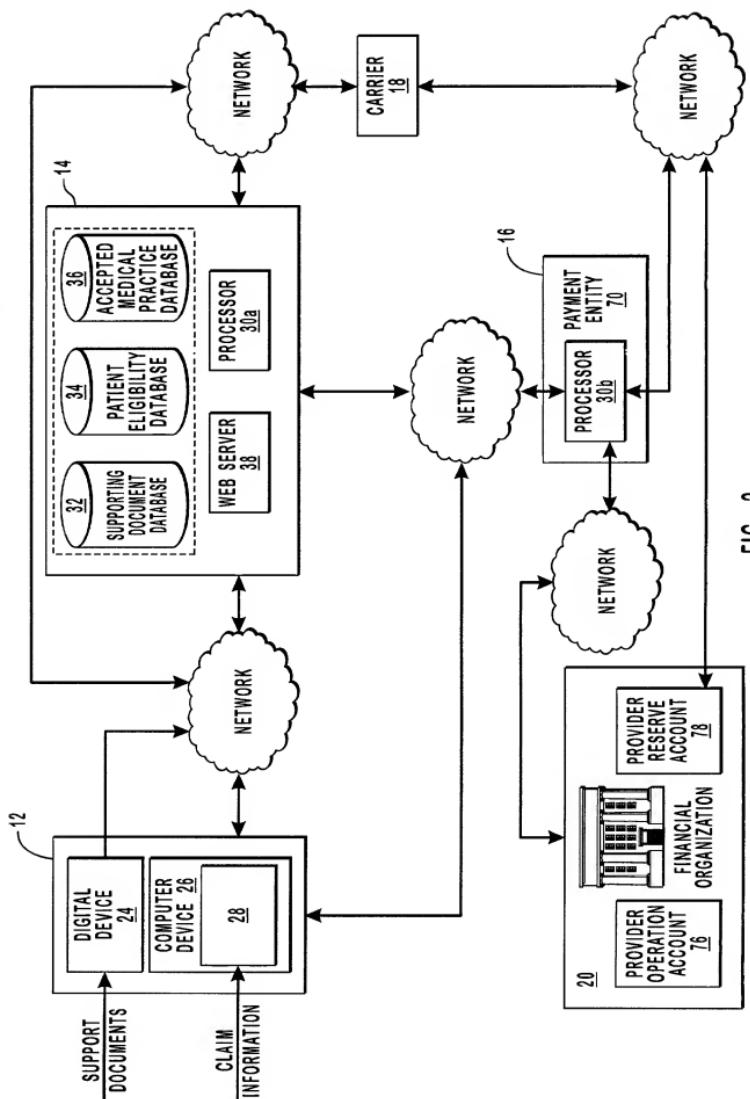


FIG. 2

28a

Health Care Claims Form	
Plan ID	40
Insured's ID	42
Patient's date of birth	- mm/dd/yy
Provider ID	

FIG. 3

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Health Care Claims Form

Plan ID : 1234
 Insured : Doe, John 541XXXXX
 Patient : 01, Jane
 Provider: MISCELLANEOUS PROVIDERS

Please enter the Patient Dependent Number from above from above: 50 56

Last Name, First, Middle Initial, I.D.							
Referring Physician							
Service Provider							
Diagnosis or Nature of Illness or Injury.							
52		52					
Dates of Service		Place	Type	Procedure, Service or Supplies			
From	To	Svc	Svc	CPT	Modifier	Diagnosis No	\$Charges
					54		60
Patient's Account		Accept Assign?			Total Charge		62
		<input type="radio"/> Yes <input checked="" type="radio"/> No			Amount Paid		58
					Balance Due		64

FIG. 4

